

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36370

Do not use this space.

NOV 15 1937

1. PLACE OF DEATH

(a) County.....

Registration District No.....

(b) Township.....

Primary Registration District No.....

(c) City St. Louis

(d) Street No. City Hospital No. 1

Registered No. 9947

(e) Length of residence in city or town where death occurred

yrs. mos. ds.

(f) How long in U. S., if of foreign birth?

yrs. mos. ds.

C. 9626

2. PRINT FULL NAME

Baby Manning

(a) Residence, No. 4561 Swan

St. 18

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Oct 1, 1937

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. nil

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

St. Louis, Missouri

FATHER

13. NAME

Walter Manning

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

MOTHER

15. MAIDEN NAME

Edna Mannors

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

17. INFORMANT (ADDRESS)

Hosp Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL

PLACE City Hospital DATE 10/29/37

19. FUNERAL DIRECTOR (ADDRESS)

David W. Jones

20. OCT 29 1937

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/2/37, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/1/37 to 10/2/37, 19

I last saw her 10/2/37 at 3.55 a m. Death is said

to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) G. Anderson

M. D.

(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)